Appendix 3: GRADE basis of recommendation decision table for screening for depression in adults

Question/Recommendation: Should primary care practitioners screen adults for depression?		
Population: Adults (18 years of age and older)		
Intervention: Screening for depression		
Setting (if relevant): Primary care settings		
Decision domain:	**Summary of reason for decision**	**Subdomains influencing decision**
Quality of evidence (QoE) *Is there high or moderate quality evidence?* Yes ☐ No ☒	**QoE for benefits of screening:** 5 quasi-experimental studies (pre–post design with a nonrandomized control group)[1–5] that examined the effect of community-based depression screening on suicide rates in the elderly population. **QoE for harms of screening:** We did not identify any eligible studies measuring the harms of screening for depression. Potential harms of screening include false positive diagnoses with subsequent unnecessary treatment; adverse effects of medication treatment among those who are correctly identified as depressed; and the consequences of labelling and stigma	**Key reasons for down- or upgrading:** **QoE for benefits:** - Directness was downgraded due to concerns about population characteristics: studies examined the elderly, rural Japanese populations which are unlikely to be representative of Canadians at average or increased risk for depression. - Directness was downgraded for the second time due to concerns regarding community-based depression screening: the intervention included screening for depression, follow-up with mental health care or psychiatric treatment, and health education in the community setting. As such, the observed reduction in suicide rates cannot be attributed solely to the screening component. - The number of events is small (<300, a threshold rule of thumb value for dichotomous outcomes); however, considering the specific outcome, the evidence was not downgraded. - Quality assessment issues: selection of non-exposed cohort, blinding and reporting of withdrawals/drop-outs; however, the evidence was not downgraded for these reasons. **QoE for harms:** Not applicable.
Balance of benefits versus harms *Is there certainty that the benefits outweigh the harm?* Yes ☐ No ☒	Given the lack of evidence for net benefit (no evidence on benefits or harms of screening), the Task Force recommends against screening the general population for depression in primary care settings. This recommendation places a relatively *high value* on the importance of demonstrating a clear net benefit before recommending routine screening for an	**Is the baseline risk for benefit similar across subgroups?** No. Certain subgroups of the population present higher prevalence rates of depression; therefore, we anticipate certain groups may benefit more if screening were to be effective; however, because of the lack of evidence, it is not possible to reach any conclusions. **Should there be separate recommendations for subgroups based on risk levels?** Possibly. **Is the baseline risk for harm similar across subgroups?** Uncertain.

	entire population and on the potential harms that may result from screening. This recommendation places a relatively *low value* on the unproven likelihood that early identification and subsequent treatment of people with depression may lead to better health outcomes (i.e., speculative benefits).	**Should there be separate recommendations for subgroups based on harm?** Possibly. **Requirement for modelling: Is there a lot of extrapolation and modelling required for these outcomes?** No eligible modeling studies were found.
Values and preferences *Is there confidence in the estimate of relative importance of outcomes and patient preferences?* Yes ☐ No ☒	There was high variability in patient preferences and values. There is some evidence showing that treatment should be culturally sensitive to be effective and that matching treatment to patient preferences improves outcomes. The Task Force believes most, but not all patients, would not want to be screened. Physicians who believe their patients, or a subset of their patients, place a high value on the potential benefits and are less concerned with potential harms would likely implement screening for these patients.	**Perspective taken:** Patient (rather than societal). **Source of values and preferences:** Relative value of importance of outcomes was determined by the guideline committee. Patient preferences were determined by a literature review. **Source of variability if any:** Not much variability for outcome importance; high variability for patient preferences. **Was method for determining values satisfactory for this recommendation?** Yes. **All critical outcomes measured?** The critical outcomes identified were: Quality-of-life; Suicidality rate (attempts or ideation);All-cause mortality; Depression related mortality; Hospitalization rates; Symptoms of depression (response or remission).
Resource implications *Are the resources worth the expected net benefit?* Yes ☐ No ☒	The Task Force did not consider costs in developing the recommendations.	**What are the costs per resource unit?** Unknown. **Feasibility: Is this intervention generally available?** Yes. **Opportunity cost: Is this intervention and its effects worth withdrawing or not allocating resources from other interventions?** No, the Task Force did not feel it was worth withdrawing resources from other interventions to screen patients given the lack of demonstrated benefit. **Is there lots of variability in resource requirements across settings?** Possibly.
Overall strength of recommendations: **WEAK**	The guideline panel recommends that asymptomatic adults at average risk for depression do not undergo routine screening in primary care settings. The guideline panel recommends that asymptomatic adults at increased risk for depression do not undergo routine screening in primary care settings.	

Remarks and values and preference statement	The recommendations places: - A high value on the importance of demonstrating a clear net benefit before recommending routine screening for an entire population. - A relatively high value on the potential harms, with the exception of use of practitioner time which is quite certain (i.e., high confidence in estimates that screening will take up clinicians' time). - A low value on the unproven likelihood that early identification and subsequent treatment of people with depression may lead to better health outcomes. Physicians who believe their patients, or a subset of their patients, place a high value on the potential benefits of screening for depression and are less concerned with potential harms would likely implement screening for these patients. Clinicians should be alert to the possibility of depression, especially in individuals with characteristics that may increase the risk for depression, and should look for it when there are clinical clues, such as insomnia, low mood, anhedonia and suicidal thoughts.

References

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